

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
04323					04324				
1. PLACE OF DEATH a. COUNTY <u>ST. MARYS</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LEONARDTOWN</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ST. MARYS Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ST. MARYS</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIDGE</u> d. STREET ADDRESS <u>RURAL</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>HENRIETTA T. BACON</u> First Middle Last 4. DATE OF DEATH <u>MARCH 10 1966</u> Month Day Year					5. SEX <u>F</u> 6. COLOR OR RACE <u>NEGRO</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-25-1884</u> 9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					13. FATHER'S NAME <u>HENRY TALTON (dec.)</u> 14. MOTHER'S MAIDEN NAME <u>ANNIE CARROLL (dec.)</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Wm H. TALTON - SAME AS # 2</u> Address					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia —</u> <u>592X</u> OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Chronic Nephritis.</u> OUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>10 yrs.</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>March 1</u> , 19 <u>66</u> , to <u>March 10</u> , 19 <u>66</u> , that (I) last saw the deceased alive on <u>March 10</u> , 19 <u>66</u> , and that death occurred at <u>10:35</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>W.H. Patrick</u>					22b. DATE SIGNED <u>3-10-66</u>				
22c. PHYSICIAN'S NAME (Type) <u>W.H. PATRICK M.D.</u>					22d. ADDRESS <u>323 MIDWAY DR. LEXINGTON PARK MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					23b. DATE THEREOF <u>3-14-66</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS</u>					23d. LOCATION (City, town or county) (State) <u>RIDGE MARYLAND</u>				
24. FUNERAL DIRECTOR <u>Robinson - Leonardtown Md.</u>					25a. REC'D BY REGISTRAR <u>MAR 14 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04330

04325

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S COUNTY NURSING HOME				d. STREET ADDRESS 328 YORKTOWN ROAD			
3. NAME OF DECEASED (Type or print) First HARRIETT Middle BECKER Last BECKER				4. DATE OF DEATH Month MARCH Day 5 Year 1966			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 29, 1881	
9. AGE (In years of birthday) yrs. 84		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Mass.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALDEN BRIGGS		14. MOTHER'S MAIDEN NAME ELVA SAMPSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-44-7099		17. INFORMANT ELIZABETH B. BOWMAN SAME AS # 2 ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis & anemia DUE TO Adenocarcinoma of Rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Jan 3/5 , 19 65 to 3/5 , 19 66 , that (I) (we) last saw the deceased alive on 3/5 , 19 66 , and that death occurred at 7:15 M, from causes and on the date stated above.							
22a. SIGNATURE James P. Jarboe				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/6/66	
22c. PHYSICIAN'S NAME (Type) JAMES P. JARBOE M. D.				22d. ADDRESS GREAT MILLS, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF MARCH 7, 1966		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND				25a. REC'D BY REGISTRAR DATE MAR 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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ST. MARY'S

WYLAND

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LEXINGTON PARK

LEONARDTOWN

ST. MARY'S COUNTY, MARYLAND

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BARON

BOWEN

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NOV. 28, 1881

WHITE

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ELVA JOHNSON

ALICE BRIDGES

JOHNSON

ELIZABETH B. BOWMAN, BORN AS A. B. ABOVE

JOHNSON

WAS THE ONLY ONE OF THE FAMILY WHO WAS A MEMBER OF THE CHURCH

THE CHURCH OF THE HOLY TRINITY

LARGE HILLS, MARYLAND

JOHN P. JOHNSON

WYLAND

NOV. 7, 1881

CREATION

LEONARDTOWN, MARYLAND

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04331 CERTIFICATE OF DEATH 04326

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - ST. INIGOEES	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARYS HOSPITAL		d. STREET ADDRESS 18-1	
3. NAME OF DECEASED (Type or print) CHARLES R. CARROLL		4. DATE OF DEATH Month MARCH Day 6 Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTURANT OWNER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	9. AGE (in years last birthday) 84 yrs.
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES H. CARROLL		14. MOTHER'S MAIDEN NAME VIRGINIA DAVIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. SAME AS # 2	
17. INFORMANT MRS. MARGUERITE DALTON		Address SAME AS # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5400 Myocardial & Circulatory Collapse Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal tubular sclerosis (c) Peptic Ulcer Hemorrhage & Shock			INTERVAL BETWEEN ONSET AND DEATH day wk 2 wks
PART II. OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1966 to 3/6 , 19 66 , that (I) was last saw the deceased alive on 3/6 , 19 66 , and that death occurred at 11:30 M, from the causes and on the date stated above.			
22a. SIGNATURE James P. Jarboe		22b. DATE SIGNED 3/7/66	
22c. PHYSICIAN'S NAME (Type) JAMES P. JARBOE M.D.		22d. ADDRESS GREAT MILLS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/8/66	
23c. NAME OF CEMETERY OR CREMATORY ST. JAMES CEMETERY		23d. LOCATION (City, town or county) (State) LEXINGTON PARK, MD.	
24. FUNERAL DIRECTOR P. D. ROBINSON		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 9 1966	

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VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04332 CERTIFICATE OF DEATH 04327

1. PLACE OF DEATH a. COUNTY St. Marys b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtowntown c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Marys Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Charlotte Hall d. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM FITZHUGH CHESLEY, Jr.		4. DATE OF DEATH Month March Day 12 Year 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1931
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Civil Service	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William F. Chesley (dec)		14. MOTHER'S MAIDEN NAME Mary E. Lyon (dec)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705 10 9053	
17. INFORMANT William R. Chesley (same as # 2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prob. recurrent coronary thrombosis 4201 DUE TO (b) Atherosclerotic C.V. disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH Instant 2 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 50 , to Mar 12 , 19 66 , that (I) (we) last saw the deceased alive on Mar 12 , 19 66 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE J. Roy Guyther		22b. DATE SIGNED 3/12/66	
22c. PHYSICIAN'S NAME (Type) J. Roy Guyther, M.D.		22d. ADDRESS Mechanicville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/15/66	
23c. NAME OF CEMETERY OR CREMATORY All Faith Cemetery		23d. LOCATION (City, town or county) (State) Charlotte Hall, Maryland	
24. FUNERAL DIRECTOR P.B. Robinson		25a. REC'D BY REGISTRAR MAR 16 1966	
ADDRESS P.B. Robinson - Leonardtown, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

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11-10-03 14:40

• Robinson - Leonard - Bayland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04333

CERTIFICATE OF DEATH

04328

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		d. STREET ADDRESS POPE	
3. NAME OF DECEASED (Type or print) First MARY Middle LIDA Last DOWNS		4. DATE OF DEATH Month MARCH Day 20 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 1900
9. AGE (In years lost birthday) yrs. 65		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE EVANS		14. MOTHER'S MAIDEN NAME ANNIE RALEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT LEWIS DOWNS		Address SAME AS # 2 ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro Intestinal Hemorrhage 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Esophageal Varices DUE TO (c) Cirrhosis of Liver		INTERVAL BETWEEN ONSET AND DEATH None ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE John F. Fenwick		22b. DATE SIGNED 3-21-66	
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M. D.		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 22, 1966	
23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS CEMETERY		23d. LOCATION (City or Town) (County) (State) HOLLYWOOD, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR MAR 22 1966	
ADDRESS LEONARDTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	

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ST. LOUIS, MO., FEB. 1, 1922.

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271192 J. AGOST

Yajima, M. 1991. *Stochastic volatility*. New York: Academic Press.

1977-1978

J. A. I. 1992

CLARK, KATHLEEN L. 1983.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 11, 13 & 14 Film G 382 11/21/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scotland Rural		c. LENGTH OF STAY IN 1b Rural Scotland 18-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Arthur Chester Eddy		4. DATE OF DEATH Month Day Year March 28 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 30, 1887
9. AGE (In years last birthday) yrs. 76		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Okoboji, Iowa, MASS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Osborne Eddy		14. MOTHER'S MAIDEN NAME Mary M. Curran	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 010-14-4618	
17. INFORMANT MARY LORETTA EDDY		18. ADDRESS SCOTLAND, MARYLAND	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4211 CALCIFIC AORTIC STENOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED March 27 66	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MARCH 28, 1966	23c. NAME OF CEMETERY OR CREMATORY EBENEZER CEMETERY	23d. LOCATION (City or Town) (County) (State) CALIFORNIA, MARYLAND
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR MAR 29 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

043310

04335

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PINEY POINT		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE First ELMER Middle GODDARD Last		4. DATE OF DEATH Month MARCH Day 2 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1898
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 6 Days 18 Hours 18 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		12. KIND OF BUSINESS OR INDUSTRY MARYLAND	
13. FATHER'S NAME RODY GODDARD		14. MOTHER'S MAIDEN NAME ELIZABETH ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220-16-8993A	
17. INFORMANT ETHEL G. GODDARD		Address PINEY POINT, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Wm D Boyd M.D. EXAMINER'S NAME (Type) WILLIAM D BOYD		22. DATE SIGNED 3/3/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 5, 1966	
23c. NAME OF CEMETERY OR CREMATORY ST. GEORGE CEMETERY		23d. LOCATION (City or Town) (County) (State) VALLEY LEE, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25. REC'D BY REGISTRAR LEONARDTOWN, MARYLAND	
25a. REGISTRAR'S SIGNATURE W. Clarke Mattingley		25b. REGISTRAR'S SIGNATURE W. Clarke Mattingley	

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FOR: LAW
04330

ST. MARY'S

ANYLAND

ST. MARY'S

SIXTY POINT

LIFE

SIXTY POINT

ST. MARY'S

ANYLAND

ANYLAND

ANYLAND

ANYLAND

ALL WHITE

ANYLAND

ANYLAND

ELIZABETH

ROBY HODGSON

ST. MARY'S, SIXTY POINT, ANYLAND

ANYLAND

ANYLAND

ST. MARY'S, SIXTY POINT, ANYLAND

ANYLAND

ANYLAND

CLARENCE BATTLES, ANYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04336											
1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtwn			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Callaway						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Mary's Hospital					d. STREET ADDRESS 18-1						
3. NAME OF DECEASED (Type or print) Infant (Girl) First Middle Last Greenwell					4. DATE OF DEATH Month March Day 10 Year 19 66						
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 9 1966		9. AGE (In years last birthday) 1 yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) St. Mary's Co., Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Eugene Arthur Daley					14. MOTHER'S MAIDEN NAME Mary Catherine Greenwell						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Mother Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7699 DUE TO Premature birth Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Influenza of mother (c) DUE TO										INTERVAL BETWEEN ONSET AND DEATH 1 day 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 4, 1966 , to March 10, 1966 , that (I) (we) last saw the deceased alive on March 9, 1966 , and that death occurred at 5 A.M. , from the causes and on the date stated above.											
22a. SIGNATURE Philip J. Bean					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/11/66				
22c. PHYSICIAN'S NAME (Type) Philip J. Bean M.D.					22d. ADDRESS Great Mills, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/11/66		23c. NAME OF CEMETERY OR CREMATORY St. Marks			23d. LOCATION (City, town or county) (State) Valley Lee Md				
24. FUNERAL DIRECTOR W. Clarke Mattingly, Leonardtown, Md.					24a. REC'D BY REGISTRAR 15		25b. REGISTRAR'S SIGNATURE Charles Judge				
MAR 15 1966											

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			c. LENGTH OF STAY in 1b 3 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEMENTS RURAL 18-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) WILLIAM IVAN HAMMETT		First Middle Last		4. DATE OF DEATH MARCH 13, 1966		Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 13, 1923		9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GENERAL MANAGER		10b. KIND OF BUSINESS OR INDUSTRY GUY CHEVROLET SALES		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD THOMAS HAMMETT				14. MOTHER'S MAIDEN NAME MARGARET MARY JONES			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 220-16-7786		17. INFORMANT Address MRS JANE E. HAMMETT CLEMENTS, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 147X DUE TO Ca of Longobitat. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca of Longobitat. (c) Ca of Longobitat.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 64 , 19 64 , to 3-13 , 19 66 , that (I) (we) last saw the deceased alive on 3-13 , 19 66 , and that death occurred at CP M, from causes and on the date stated above.							
22a. SIGNATURE Michael Barraville, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-14-66			
22c. PHYSICIAN'S NAME (Type) Michael Barraville, M.D.		22d. ADDRESS Leonardtown, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MARCH 16, 1966	23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY		23d. LOCATION (City or Town) (County) (State) BUSHWOOD, MARYLAND			
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND				25a. REC'D BY REGISTRAR APR 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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THIS IS A PRELIMINARY REPORT AND SHOULD NOT BE USED FOR
OFFICIAL PURPOSES WITHOUT THE APPROVAL OF THE
OFFICE OF THE ATTORNEY GENERAL.

BURIAL

MARCH 1, 1954 SAGGED HART CEMETERY, BUSHWOOD, ARKANSAS

W. LARKS, ATTORNEY, LEONARDTOWN, ARKANSAS

MR. J. H. WHITE, 1111 N. 1ST ST., LEONARDTOWN, ARKANSAS

EDWARD THOMAS HAMMETT, 1111 N. 1ST ST., LEONARDTOWN, ARKANSAS

GENERAL MANAGER, GUY CHEVROLET SALES, ARKANSAS, U.S.A.

WHITE

APRIL 13, 1954

WILLIAM

IVAN

HAMMETT

BARON

ST. MARY'S HOSPITAL

LEONARDTOWN

3 DAY

CLEMENTS

RURAL

ST. MARY'S

ARLYLAND

ST. MARY'S

1954

LEONARDTOWN, ARKANSAS

1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04338

04333

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			c. LENGTH OF STAY IN 1b 20 HRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS Rt. 2 ST CLEMENTS SHORES		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JOHN Middle LEWIS Last RUSSELL				4. DATE OF DEATH Month MARCH Day 7 Year 19 66				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 16, 1890		
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN RUSSELL				14. MOTHER'S MAIDEN NAME MARY ALICE ABELL				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-50-2243		17. INFORMANT MRS LILLIAN I. RUSSELL SAME AS # 2 ABOVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism + Multiple emboli 4331 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atrial fibrillation = atrial thrombus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH 24	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.								
22a. SIGNATURE <i>John F. Fenwick</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-8-66		
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M. D.				22d. ADDRESS LEONARDTOWN, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 10, 1966		23c. NAME OF CEMETERY OR CREMATORY ST. ALOYSIUS CEMETERY		23d. LOCATION (City or Town) (County) (State) LEONARDTOWN, MARYLAND		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND				25a. REC'D BY REGISTRAR MAR 9 1966		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

U-338

04338

T. HARRY'S

WYLAND

U. HARRY'S

LEONARDTOWN

23 HRS

EDWARDSON

ST. CLARENCE HOSPITAL

ST. HARRY'S HOSPITAL

WAGON

SUB-ALL

LEWIS

CONY

JULY 1, 1920

WHITE

WALL

WYLAND

FARMER

GRAY-BLICK FORD

JOHN HUBBELL

WILLIAM I. HUBBELL, DANCER, 52 ABOVE

LEONARDTOWN, WYLAND

JOHN E. HICK

WYLAND

MARCH 10, 1920

BURIAL

W. CLARK HAYES, LEONARDTOWN, WYLAND

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Form G375 3/28/66 mh

CERTIFICATE OF DEATH

04339

04334

1. PLACE OF DEATH a. COUNTY <u>St Mary</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leandroptown</u>		c. LENGTH OF STAY in 1b <u>18 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> <u>83-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St Mary's Hospital</u>				d. STREET ADDRESS <u>2400 N. Florida St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARL Stone</u> First Middle Last				4. DATE OF DEATH Month <u>MARCH</u> Day <u>21</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-8-10</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army map service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Corps of Engineers</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MARVIN ANGLE</u>				14. MOTHER'S MAIDEN NAME <u>WILLIE STONE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>Peacetime</u>		16. SOCIAL SECURITY NO. <u>579-01-9101</u>		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mch 20</u> , 19 <u>66</u> , to <u>Mch 21</u> , 19 <u>66</u> that (I) (<u>we</u>) last saw the deceased alive on <u>Mch 20</u> , 19 <u>66</u> , and that death occurred at <u>3A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>W.H. Patrick</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-21-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM H. PATRICK M. D.</u>				22d. ADDRESS <u>LEXINGTON PARK, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>23 March 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Ives Funeral Home, Inc.</u>				ADDRESS <u>2847 Wilson Blvd. Arl. Va</u>		25a. REC'D BY REGISTRAR <u>MAR 24 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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043391

DEPARTMENT OF HEALTH

043391

LABOR

WILLIAM H. PATRICK

WILLIAM H. PATRICK

1906-1907

WASHINGTON, D.C.

WILLIAM H. PATRICK, D.C.

Washington, D.C.

23 March 1906 N.Y. Times Company

Printed

Two Annual Reports, No. 2, New York City, N.Y.

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1

M

04340

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04335

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS 18-1			
3. NAME OF DECEASED (Type or print) First Middle Last (PATTIE) MARY PACCIARINE STONE				4. DATE OF DEATH Month Day Year MARCH 16, 1966			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 12, 1880	
9. AGE (In years last birthday) yrs. 86		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) DYNARD, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME LEWIS BRIGGS STONE				14. MOTHER'S MAIDEN NAME MARY EMMA HERBERT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Ca of Breast (post surgical)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Jan 15, 1966 to March 16, 1966 , that (I) (we) last saw the deceased alive on March 15, 1966 , and that death occurred at 1 P M, from causes and on the date stated above.							
22a. SIGNATURE W.D. Boyd				22b. DATE SIGNED 3/17/66		22c. PHYSICIAN'S NAME (Type) WILLIAM D. BOYD M. D.	
22d. ADDRESS LEONARDTOWN, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 19, 1966		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY		23d. LOCATION (City or Town) (County) (State) BUSHWOOD, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY				ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR MAR 22 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

CERTIFICATE OF DEATH

00333

00333

ST. MARY'S

HARRISBURG

ST. MARY'S

HARRISBURG

HARRISBURG

ST. MARY'S HOSPITAL

ST. MARY'S

HARRISBURG

HARRISBURG

HARRISBURG

JAN. 12, 1980

WHITE

HARRISBURG

HARRISBURG

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04341

04336

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River			c. LENGTH OF STAY IN 1b 1 hr 50 min	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park			18-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAS Station Hospital				d. STREET ADDRESS 19 Officers Court			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Tate				4. DATE OF DEATH Month March Day 2 Year 19 66			
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1966		9. AGE (In years last birthday) yrs. 1 Months 50 Days 1 Min.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) St. Mary's Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Hutchins Tate				14. MOTHER'S MAIDEN NAME Mary Anita Oakes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Father		Address Same as #2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7735 Respiratory failure DUE TO (b) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH 1hr 50min 1hr 50min
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 2, 1966 , to March 2, 1966 that (I) (we) last saw the deceased alive on March 2, 1966 , and that death occurred at 1040AM , from causes and on the date stated above.							
22a. SIGNATURE P. B. CLOHERTY, Lt MC USN				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-2-66	
22c. PHYSICIAN'S NAME (Type) P. B. CLOHERTY, Lt MC USN				22d. ADDRESS Same as # 1.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/3/66		23c. NAME OF CEMETERY OR CREMATORY EBENEZER CEMETERY		23d. LOCATION (City or Town) (County) (State) GREAT MILLS, MARYLAND	
24. FUNERAL DIRECTOR P.B. ROBINSON - LEONARDTOWN, MARYLAND				25a. REC'D BY REGISTRAR MAR 7 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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05820

0730 10 1740 100

05820

3

1. NAME OF VESSEL		2. TYPE OF VESSEL		3. HOME PORT	
4. DATE OF DEPARTURE		5. TIME OF DEPARTURE		6. DESTINATION	
7. NAME OF CAPTAIN		8. NAME OF MASTER		9. NAME OF FIRST OFFICER	
10. NAME OF SECOND OFFICER		11. NAME OF THIRD OFFICER		12. NAME OF FOURTH OFFICER	
13. NAME OF FIFTH OFFICER		14. NAME OF SIXTH OFFICER		15. NAME OF SEVENTH OFFICER	
16. NAME OF EIGHTH OFFICER		17. NAME OF NINTH OFFICER		18. NAME OF TENTH OFFICER	
19. NAME OF ELEVENTH OFFICER		20. NAME OF TWELFTH OFFICER		21. NAME OF THIRTEENTH OFFICER	
22. NAME OF FOURTEENTH OFFICER		23. NAME OF FIFTEENTH OFFICER		24. NAME OF SIXTEENTH OFFICER	
25. NAME OF SEVENTEENTH OFFICER		26. NAME OF EIGHTEENTH OFFICER		27. NAME OF NINETEENTH OFFICER	
28. NAME OF TWENTIETH OFFICER		29. NAME OF TWENTY-FIRST OFFICER		30. NAME OF TWENTY-SECOND OFFICER	
31. NAME OF TWENTY-THIRD OFFICER		32. NAME OF TWENTY-FOURTH OFFICER		33. NAME OF TWENTY-FIFTH OFFICER	
34. NAME OF TWENTY-SIXTH OFFICER		35. NAME OF TWENTY-SEVENTH OFFICER		36. NAME OF TWENTY-EIGHTH OFFICER	
37. NAME OF TWENTY-NINTH OFFICER		38. NAME OF THIRTIETH OFFICER		39. NAME OF THIRTY-FIRST OFFICER	
40. NAME OF THIRTY-SECOND OFFICER		41. NAME OF THIRTY-THIRD OFFICER		42. NAME OF THIRTY-FOURTH OFFICER	
43. NAME OF THIRTY-FIFTH OFFICER		44. NAME OF THIRTY-SIXTH OFFICER		45. NAME OF THIRTY-SEVENTH OFFICER	
46. NAME OF THIRTY-EIGHTH OFFICER		47. NAME OF THIRTY-NINTH OFFICER		48. NAME OF FORTY OFFICER	
49. NAME OF FORTY-FIRST OFFICER		50. NAME OF FORTY-SECOND OFFICER		51. NAME OF FORTY-THIRD OFFICER	
52. NAME OF FORTY-FOURTH OFFICER		53. NAME OF FORTY-FIFTH OFFICER		54. NAME OF FORTY-SIXTH OFFICER	
55. NAME OF FORTY-SEVENTH OFFICER		56. NAME OF FORTY-EIGHTH OFFICER		57. NAME OF FORTY-NINTH OFFICER	
58. NAME OF FIFTY OFFICER		59. NAME OF FIFTY-FIRST OFFICER		60. NAME OF FIFTY-SECOND OFFICER	
61. NAME OF FIFTY-THIRD OFFICER		62. NAME OF FIFTY-FOURTH OFFICER		63. NAME OF FIFTY-FIFTH OFFICER	
64. NAME OF FIFTY-SIXTH OFFICER		65. NAME OF FIFTY-SEVENTH OFFICER		66. NAME OF FIFTY-EIGHTH OFFICER	
67. NAME OF FIFTY-NINTH OFFICER		68. NAME OF SIXTY OFFICER		69. NAME OF SIXTY-FIRST OFFICER	
70. NAME OF SIXTY-SECOND OFFICER		71. NAME OF SIXTY-THIRD OFFICER		72. NAME OF SIXTY-FOURTH OFFICER	
73. NAME OF SIXTY-FIFTH OFFICER		74. NAME OF SIXTY-SIXTH OFFICER		75. NAME OF SIXTY-SEVENTH OFFICER	
76. NAME OF SIXTY-EIGHTH OFFICER		77. NAME OF SIXTY-NINTH OFFICER		78. NAME OF SEVENTY OFFICER	
79. NAME OF SEVENTY-FIRST OFFICER		80. NAME OF SEVENTY-SECOND OFFICER		81. NAME OF SEVENTY-THIRD OFFICER	
82. NAME OF SEVENTY-FOURTH OFFICER		83. NAME OF SEVENTY-FIFTH OFFICER		84. NAME OF SEVENTY-SIXTH OFFICER	
85. NAME OF SEVENTY-SEVENTH OFFICER		86. NAME OF SEVENTY-EIGHTH OFFICER		87. NAME OF SEVENTY-NINTH OFFICER	
88. NAME OF EIGHTY OFFICER		89. NAME OF EIGHTY-FIRST OFFICER		90. NAME OF EIGHTY-SECOND OFFICER	
91. NAME OF EIGHTY-THIRD OFFICER		92. NAME OF EIGHTY-FOURTH OFFICER		93. NAME OF EIGHTY-FIFTH OFFICER	
94. NAME OF EIGHTY-SIXTH OFFICER		95. NAME OF EIGHTY-SEVENTH OFFICER		96. NAME OF EIGHTY-EIGHTH OFFICER	
97. NAME OF EIGHTY-NINTH OFFICER		98. NAME OF NINETY OFFICER		99. NAME OF NINETY-FIRST OFFICER	
100. NAME OF NINETY-SECOND OFFICER		101. NAME OF NINETY-THIRD OFFICER		102. NAME OF NINETY-FOURTH OFFICER	
103. NAME OF NINETY-FIFTH OFFICER		104. NAME OF NINETY-SIXTH OFFICER		105. NAME OF NINETY-SEVENTH OFFICER	
106. NAME OF NINETY-EIGHTH OFFICER		107. NAME OF NINETY-NINTH OFFICER		108. NAME OF HUNDRED OFFICER	
109. NAME OF HUNDRED-FIRST OFFICER		110. NAME OF HUNDRED-SECOND OFFICER		111. NAME OF HUNDRED-THIRD OFFICER	
112. NAME OF HUNDRED-FOURTH OFFICER		113. NAME OF HUNDRED-FIFTH OFFICER		114. NAME OF HUNDRED-SIXTH OFFICER	
115. NAME OF HUNDRED-SEVENTH OFFICER		116. NAME OF HUNDRED-EIGHTH OFFICER		117. NAME OF HUNDRED-NINTH OFFICER	
118. NAME OF HUNDRED-TENTH OFFICER		119. NAME OF HUNDRED-ELEVENTH OFFICER		120. NAME OF HUNDRED-TWENTY OFFICER	
121. NAME OF HUNDRED-TWENTY-ONE OFFICER		122. NAME OF HUNDRED-TWENTY-TWO OFFICER		123. NAME OF HUNDRED-TWENTY-THREE OFFICER	
124. NAME OF HUNDRED-TWENTY-FOUR OFFICER		125. NAME OF HUNDRED-TWENTY-FIVE OFFICER		126. NAME OF HUNDRED-TWENTY-SIX OFFICER	
127. NAME OF HUNDRED-TWENTY-SEVEN OFFICER		128. NAME OF HUNDRED-TWENTY-EIGHT OFFICER		129. NAME OF HUNDRED-TWENTY-NINE OFFICER	
130. NAME OF HUNDRED-THIRTY OFFICER		131. NAME OF HUNDRED-THIRTY-ONE OFFICER		132. NAME OF HUNDRED-THIRTY-TWO OFFICER	
133. NAME OF HUNDRED-THIRTY-THREE OFFICER		134. NAME OF HUNDRED-THIRTY-FOUR OFFICER		135. NAME OF HUNDRED-THIRTY-FIVE OFFICER	
136. NAME OF HUNDRED-THIRTY-SIX OFFICER		137. NAME OF HUNDRED-THIRTY-SEVEN OFFICER		138. NAME OF HUNDRED-THIRTY-EIGHT OFFICER	
139. NAME OF HUNDRED-THIRTY-NINE OFFICER		140. NAME OF HUNDRED-FORTY OFFICER		141. NAME OF HUNDRED-FORTY-ONE OFFICER	
142. NAME OF HUNDRED-FORTY-TWO OFFICER		143. NAME OF HUNDRED-FORTY-THREE OFFICER		144. NAME OF HUNDRED-FORTY-FOUR OFFICER	
145. NAME OF HUNDRED-FORTY-FIVE OFFICER		146. NAME OF HUNDRED-FORTY-SIX OFFICER		147. NAME OF HUNDRED-FORTY-SEVEN OFFICER	
148. NAME OF HUNDRED-FORTY-EIGHT OFFICER		149. NAME OF HUNDRED-FORTY-NINE OFFICER		150. NAME OF FIFTY	

RECEIVED
U.S. CUSTOMS AND BORDER PROTECTION
PORT OF NEW YORK AND GEORGE TOWN
JAN 10 1964
OFFICE OF THE DISTRICT ATTORNEY
NEW YORK, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04342

CERTIFICATE OF DEATH

04337

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL MADDOX 18-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S COUNTY NURSING HOME				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle LOUISE Last TEGETHOFF		4. DATE OF DEATH Month MARCH Day 22 Year 1966					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 5, 1879		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CHARLES COUNTY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FREDERICK ALBERT RICHMOND				14. MOTHER'S MAIDEN NAME ANNIE ELIZA WIGNELL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT MRS WINIFRED LYON MADDOX, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X CVA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH 2 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June 1, 1963 , to March 22, 1966 , that (I) (we) last saw the deceased alive on March 18, 1966 , and that death occurred at 6 P M, from causes and on the date stated above.							
22a. SIGNATURE W.D. Boyd				22b. DATE SIGNED 3/23/66		22c. PHYSICIAN'S NAME (Type) WILLIAM D. BOYD M. D.	
22d. ADDRESS LEONARDTOWN, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 25, 1966	23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C.		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND				25a. REC'D BY REGISTRAR MAR 29 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

04394

04394

ST. MARY'S

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of body in any event, within 72 hours after death.

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76

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04343

CERTIFICATE OF DEATH

04338

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			c. LENGTH OF STAY IN 1b 51 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HOLLYWOOD,		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAISY Middle CATHERINE Last THOMPSON				4. DATE OF DEATH Month MARCH Day 26, Year 19 66			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 5, 1888	
9. AGE (In years last birthday) 77 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ST. MARY'S, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME SAMUEL JONES			
14. MOTHER'S MAIDEN NAME ANNIE KING				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT P. ROSCOE THOMPSON Address HOLLYWOOD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure (Atherosclerosis) DUE TO Uremia and Diabetic Nephropathy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							INTERVAL BETWEEN ONSET AND DEATH 30 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred on _____ M, from causes and on the date stated above.							
22a. SIGNATURE John F. Fenwick M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-28-66	
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M. D.				22d. ADDRESS LEONARDTOWN, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 29, 1966		23c. NAME OF CEMETERY OR CREMATORY JOY CHAPEL		23d. LOCATION (City or Town) (County) (State) HOLLYWOOD, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND				25a. REC'D BY REGISTRAR DATE MAR 29 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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STATE OF TEXAS

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1. NAME

2. ADDRESS

3. CITY

4. COUNTY

5. STATE

6. ZIP CODE

7. PHONE NUMBER

8. SEX

9. AGE

10. OCCUPATION

11. EDUCATION

12. MARITAL STATUS

13. DATE OF BIRTH

14. RACE

15. ETHNICITY

16. SOCIAL SECURITY NUMBER

17. VOTER REGISTRATION

18. MILITARY SERVICE

19. EMPLOYMENT HISTORY

20. CREDIT HISTORY

21. CURRENT RESIDENCE

22. PREVIOUS RESIDENCES

23. CURRENT EMPLOYER

24. CURRENT EMPLOYMENT TYPE

25. CURRENT EMPLOYMENT DURATION

26. CURRENT EMPLOYMENT START DATE

27. CURRENT EMPLOYMENT END DATE

28. CURRENT EMPLOYMENT ADDRESS

29. CURRENT EMPLOYMENT PHONE NUMBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and deposit them with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN lb 11 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		d. STREET ADDRESS P.O.Box 18	
3. NAME OF DECEASED (Type or print) First PETER Middle COLUMBUS Last WHEELER		4. DATE OF DEATH Month MARCH Day 1 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 14, 1874
9. AGE (In years lost birthday) 91 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES WHEELER		14. MOTHER'S MAIDEN NAME LYDIA ANN GODDARD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs LOUISE R. WHEELER		Address LEONARDTOWN, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October, 1956 , to March 1, 1966 , that (I) (we) last saw the deceased alive on Feb 28 1966 , and that death occurred at 2:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE P. J. BEAN		22b. DATE SIGNED March 2/66	
22c. PHYSICIAN'S NAME (Type) P. J. BEAN M.D.		22d. ADDRESS GREAT MILLS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 5, 1966	
23c. NAME OF CEMETERY OR CREMATORY HOLY FACE CEMETERY		23d. LOCATION (City or Town) (County) (State) GREAT MILLS, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR DATE MAR 4 1966	
ADDRESS LEONARDTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

04330

RECORDS OF DEATH

04330

ST. MARY'S

MARYLAND

ST. MARY'S

LEONARDTOWN

11 DAYS

LEONARDTOWN

ST. MARY'S HOSPITAL

P. J. BEAR

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OCT. 1, 1934

WHITE

AGE

MARYLAND

LYTIA ANN EDDARD

JAMES WHEELER

MRS LOUISE R. WHEELER LEONARDTOWN, MARYLAND

GREAT HILLS, MARYLAND

P. J. BEAR M.D.

MARYLAND

GREAT HILLS

ST. MARY'S

MARCH, 1934

BURIAL

W. CLARK ATTORNEY LEONARDTOWN, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. LENGTH OF STAY IN 1b 12-1							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARYS NURSING HOME					d. STREET ADDRESS 315 YORKTOWN RD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) RETA			First		Middle		Last		4. DATE OF DEATH MARCH 28 1966		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/4/1883		9. AGE (in years last birthday) 82 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (County & State, or foreign country) CONNECTICUT			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOHN EUSTICE					14. MOTHER'S MAIDEN NAME DENSEY MESSENGER						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 215 54 8246		17. INFORMANT MRS. ARTHUR E. ADAMS			Address SAME AS #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> (b) <i>Generalized Atherosclerosis</i> (c) <i>Hypertensive Heart Disease</i>										INTERVAL BETWEEN ONSET AND DEATH 20 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fractured Right Hip</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>March</i> , 19 <i>65</i> , to <i>28 March</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>25 May</i> , 19 <i>66</i> , and that death occurred at <i>1:30</i> P.M., from the causes and on the date stated above.											
22a. SIGNATURE <i>Ernest D. Rehm</i>								22b. DATE SIGNED 3/29/66			
22c. PHYSICIAN'S NAME (Type) ERNEST REHM M.D.								22d. ADDRESS LEXINGTON PARK, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 3/30/66		23c. NAME OF CEMETERY OR CREMATORY TRINITY CEMETERY			23d. LOCATION (City, town or county) (State) ST. MARYS CITY, MARYLAND			
24. FUNERAL DIRECTOR <i>P.B. Robinson</i>						25a. REC'D BY REGISTRAR MAR 31 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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ST. PAUL, MINN. 10-10-68

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04346

CERTIFICATE OF DEATH

04341

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			c. LENGTH OF STAY IN 1b 3 HRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK,		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS 335 YORKTOWN ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GRACE Middle ELLEN Last WHOLAVER			4. DATE OF DEATH Month MARCH Day 3 Year 19 66				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 29, 1896		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) JEFFERSON, OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? ?			14. MOTHER'S MAIDEN NAME ? ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT CHARLES ROBERT WHOLAVER SAME AS # 2 ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Circulatory Collapse DUE TO (b) Ruptured Aortic Aneurysm DUE TO (c) Hypertensive A-S-C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 4 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1/1 , 19 65 , to 3/3 , 19 66 , that (I) (we) last saw the deceased alive on 3/3 , 19 66 , and that death occurred at 4:30 M, from causes and on the date stated above.							
22a. SIGNATURE James P. Jarboe		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/3/66			
22c. PHYSICIAN'S NAME (Type) JAMES PATRICK JARBOE M. D.		22d. ADDRESS GREAT MILLS, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 8, 1966	23c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY		23d. LOCATION (City or Town) (County) (State) COLUMBUS, OHIO		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND			25a. REC'D BY REGISTRAR MAR 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

013341

CERTIFICATE OF DEATH

1934

ST. MARY'S

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ST. MARY'S

LEXINGTON PARK,

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LEXINGTON PARK

333 YORKSTOWN ROAD

ST. MARY'S HOSPITAL

MARCH

WHEELER

ELLEN

GRADE

WHITE

JULY 27, 1934

CHICAGO, ILL.

CHICAGO, ILL.

CHARLES ROBERT WHEELER, BORN IN S. S. ABOVE

WIFE

WIFE

MARCH 3, 1934

CHICAGO

CHICAGO, ILL.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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FOR STATE
HEALTH DEPT. (M)

04347

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04342

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HELEN 18-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSETTA Middle FAYE Last YOUNG				4. DATE OF DEATH Month MARCH Day 19 Year 1966			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 10, 1966		9. AGE (In years last birthday) yrs. 1 Months 9 Days 9 Hours Min.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH WALLACE YOUNG				14. MOTHER'S MAIDEN NAME AGNES MADELINE HILL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MOTHER Address SAME AS # 2 ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE William D. Boyd M. D.		EXAMINER'S NAME (Type) WILLIAM D. BOYD M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 3/21/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 21, 1966		23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPHS CEMETERY		23d. LOCATION (City or Town) (County) (State) MORGANZA, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY ADDRESS LEONARDTOWN, MARYLAND				25a. REC'D BY REGISTRAR MAR 22 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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